Printed: 11/11/2009 2:12:34PM
Due Date: 02/04/2009
Priority: Non-IJ High

Intake ID: NV00020672
Facility ID: NVS2489AGC / AGC
Provider Number:

ACTS Complaint/Incident Investigation Report

PROVIDER INFORMATION

Name: CHANCELLOR GARDENS OF THE LAKE
Address: 2620 LAKE SAHARA DRIVE
City/State/Zip/County: LAS VEGAS, NV, 89117, CLARK
Telephone: (702) 233-9800

License #:
Type: AGC
Medicaid #:
Administrator: NANA GYEABOUR

INTAKE INFORMATION

Taken by - Staff: [redacted]
Location Received: SOUTHERN NEVADA
Intake Type: Complaint
Intake Subtype: State-only, licensure
External Control #:
SA Contact: [redacted]
RO Contact:
Responsible Team: SOUTHERN NEVADA
Source: Family

Received Start: 01/15/2009 At 13:17
Received End: 01/21/2009 At 13:17
Received by: Written
State Complaint ID:
CIS Number:

COMPLAINANTS

Name	Address	Home Phone	Work Phone	Link ID
[redacted]	[redacted]		[redacted]	099WQW
Relationship: [redacted]				
[redacted]	[redacted]		[redacted]	09V9XH
Relationship: [redacted]				

RESIDENTS/PATIENTS/CLIENTS

Name	Admitted	Location	Room	Discharged	Link ID
[redacted]					1386028

ALLEGED PERPETRATORS - No Data

INTAKE DETAIL

Date of Alleged Event: Time: Shift:

Standard Notes: Failed to ensure neglect and exploitation did not happen to patient.

Per the letter attached the facility should be fined:

Assessment of monetary penalties of at least $9,900 for reimbursement to [redacted] estate for medication management fees assessed by Chancellor Gardens and paid by [redacted] because Chancellor Gardens failed to provide medication management services.

It is this action in which the family feels that the pt. was exploited.

****

Failed to clean the resident's Room

On September 9, 2008, [redacted] visited [redacted] at Chancellor Gardens and learned of the substandard, unsanitary conditions in which [redacted] was living. Her room was unkempt and it appeared that no housekeeping had been done for quite some time. The room reeked of cat urine and bags of trash were everywhere. Old newspapers soaked with cat urine had accumulated three inches deep in [redacted] closet.

A baggie containing several months' supply of [redacted] accumulated medications, not administered to or taken by [redacted], was found in the drawer of her dresser. Copies of photographs taken by [redacted] are attached hereto as Attachment Five.)

ACTS Complaint/Incident Investigation Report

****

Failed to administer medications.

In accord with a Physician Assessment dated December 10,2005, Chancellor Gardens was on notice that [redacted] s "forgetful at times," and unable to administer her own medications. The medications listed on the form included Namenda and Aricept, drugs prescribed to treat moderate to severe dementia. Used in concert, Namenda and Aricept are intended to help a patient with dementia improve and maintain thinking, significantly improve behavior, delay the onset of negative behavioral symptoms, and maintain the ability to perform activities of daily living.

Upon seeing the condition of the room and finding [redacted]' medication, [redacted] asked [redacted], the Executive Director of Chancellor Gardens, and [redacted] a RN and Chancellor Gardens ' Wellness Director in charge of residential care and services for [redacted] why the room had not been cleaned. [redacted] esponded that [redacted] would not let them in to clean the room because of her cat. However, due to her dementia, [redacted] was not in a position to decide whether her room needed cleaning.

[redacted] also inquired about the accumulation of pills in [redacted] drawer and was told by [redacted] incorrectly, that [redacted] was a "self-medicator." [redacted] hen tried to take the bag of pills from [redacted] but she refused to hand them over. [redacted] retains the bag of pills and can produce it if desired. [redacted] an authenticate the bag, if desired, because - when [redacted] refused to give it to him - he took a picture of the bag of pills with his camera phone.

2/25/2009: I have just had a detailedconversation with [redacted] of the deceased patient, during which I explained the entire complaint process that is followed. I invited him to call again at any time. He can be reached as follows: [redacted].

Extended RO Notes:

Extended CO Notes:

ALLEGATIONS

Category: Resident/Patient/Client Neglect
Subcategory: Medications
Seriousness:
Findings: Unsubstantiated:Lack of sufficient evidence
Details:

Findings Text:

Category: Quality of Care/Treatment
Subcategory: Resident Not Groomed Adequately
Seriousness:
Findings: Unsubstantiated:Lack of sufficient evidence
Details:

Findings Text:

SURVEY INFORMATION

Event ID	Start Date	Exit Date	Team Members	Staff ID
CTDT11	02/04/09	02/05/09	[redacted]	27177
			[redacted]	27469

Intakes Investigated: NV00018987(Received: 08/20/2008); NV00020672(Received: 01/21/2009)

ACTS Complaint/Incident Investigation Report

SUMMARY OF CITATIONS:

Event ID	Exit Date	Tag
CTDT11	02/05/2009	

State - Not Related to any Intakes

Y0000-Initial Comments
Y1020-Chronic Illness Training
Y0103-Personnel File - NAC 441A
Y0106-Personnel File - 1st aid & CPR
Y0173-Health and Sanitation-Inside garbage
Y0175-Health and Sanitation-Hazards
Y0179-Health and Sanitation-Screens
Y0250-Kitchens-Equipment works; Clean and Sanitary
Y0251-Storage of Food-Perishable foods refrigerated
Y0278-Dietary Consultant - More Than 10 Residents
Y0352-Bathrooms and Toilet Facilities
Y0451-First Aid Kit
Y0645-Rate Agreement
Y0859-Periodic Physical examination of a resident
Y0870-449.2742(1)(a)(1) Medication Administration
Y0876-NRS 449.037
Y0878-Medication / Change order
Y0882-Medication / change order
Y0922-Medication Labeling
Y0933-Resident File-Mental, Physical Condition
Y0936-Resident file-NRS 441A Tuberculosis
Y0938-Resident file - ADL Evaluation Admission
Y0941-Resident file - Facility Rules
Y0991-449.2756(1)(b) Alzheimer's Fac door alarm
Y0993-449.2756(1)(d) Alzheimer's training
Y0999-Alzheimer's Facility-Toxic substances
Y1001-Training Req-Elderly Disabled
Y1010-MI Training
Y0070-Qualifications of Caregiver-8 hours training

EMTALA INFORMATION - No Data

ACTIVITIES

Type	Assigned	Due	Completed	Responsible Staff Member
Schedule Onsite Visit	02/04/2009	02/04/2009	02/05/2009	[redacted]

ACTS Complaint/Incident Investigation Report

INVESTIGATIVE NOTES

Complaint # NV00020672 was investigated using interview and record review on 2/4 and 2/5/09.

Allegation: #1 Resident room not cleaned.
#2 Medications not administered

Record Review:

The resident record on admit contained an evaluation of Category 1 (which is oriented x3) on 1/9/07. [redacted] resided on the Assisted Living unit at Chancellor Gardens. There is no further evaluation of cognitive status in the resident record reviewed. It was noted that on 1/25/08 the resident refused to allow 2 hour checks on her status.

In June and July 2008 resident remained independent in activities of daily living per the personal care record. There is no notation of her mental status. It appears that she needed a reminder to take her meds later in the day but was independent in medication management early in the day.

Resident notes on 9/4/08 at 1220 PM indicate resident not feeling well and complained of chronic pain. Her vital signs were 97.2-84-24 and 118/64.

Notes on 9/5/08 at 11:40 AM resident had not been down for meals for two days. [redacted] stated "my bones hurt". It was noted at this time she was not talkative and was unkept with an odor of urine about her. It was further indicated she had been doing her own laundry but now needed assistance. Her vital signs were 98.8-84-20 and 108/60. Her physician was contacted and he ordered Levaquin and Compazine.

On 9-6-08 at 5:30 PM it was noted [redacted] face was bloody. She revealed that she had fallen off her couch and landed on her face on the carpet. She had abrasions on her face which were cleansed.

The next recorded information available is a Transfer summary from Summerlin Hospital dated 9/15/08/ The summary noted [redacted] was admitted to Summerlin on 9/7/08 with Altered mental status, hypoxemia, sepsis, pneumonia, pulmonary nodules, electrolyte imbalance, azotemia, status post small bowel obstruction, elevated CA-125 and D-dimer. The tranfer summary concludes [redacted] is to be transferred to Comfort Care Hospice for further management.

The Hospice notes indicate an admission date of 9/15/08. (She was apparently sent to Las Ventanas initially and later transferred to the Memory Care Unit at Chancellor Gardens.) Her vital signs were 98-72-28 and 96/64.

The next Hospice notes are dated 9/18/08 and note a weak thready pulse with vital signs of 97.8-50-23 and 74/32. She had a distended abdomen and required an enema.

On 9/19/08 at 9:15 AM Hospice again visited. Her abdomen was distended and bowel sounds were hypoactive.

On 9/20/08 at 8:50 AM [redacted] expired.

Interview:

On 2/5/09 at 11:10 AM interview with [redacted], Alzheimer's Coordinator, revealed that [redacted] cleaned her cat box by herself until the last week she went into the hospital in September 2008. While she was in the hospital the facility staff cleaned her cat box. When [redacted] returned to Chancellor Gardens and was placed on the Memory Care Unit the cat continued to reside in her previous room and visited her on the Memory Care Unit. The facility staff continued to care for the cat.

[redacted] related that during the time [redacted] was on the Memory Care Unit before her death family members came and cleaned out her room on Assisted Living. There were several garbage bags of trash collected. According to [redacted] had ordered a lot of groceries to be delivered which were stored in her room on Assisted Living. There was also a lot of paper stuffed in the drawers in her room.

[redacted] revealed she is not aware of any medication management or room cleanliness issues prior to [redacted] admission to Summerlin Hospital on 9/7/08. When she returned to Chancellor Gardens after the hospitalization she was too sick to provide any self care.

Complaint #NV00020672 unsubstantiated due to lack of evidence.

[redacted]

CONTACTS - No Data

AGENCY REFERRAL - No Data

LINKED COMPLAINTS - No Data

DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

NOTICES

Letters:

Created	Description

Notification:

Date	Type	Party	Method

ACTS Complaint/Incident Investigation Report

PROPOSED ACTIONS

Proposed Action	Proposed Date	Imposed Date	Type
State Only Actions	02/05/2009		Federal
None	02/05/2009		State

Closed: 04/28/2009 **Reason:** Paperwork Complete

END OF COMPLAINT INVESTIGATION INFORMATION

Facility ID: NVS2489AGC
Provider Number:

COMPLAINT/INCIDENT SURVEY REPORT
02/05/2009

PROVIDER INFORMATION:

Name: CHANCELLOR GARDENS OF THE LAKE
Address: 2620 LAKE SAHARA DRIVE
City/State/Zip/County: LAS VEGAS, NV, 89117, CLARK
Telephone: (702) 233-9800

License #:
Type: AGC
Medicaid #:
Administrator: NANA GYEABOUR

SURVEY INFORMATION:

Event ID	Start Date	Exit Date	2567 Sent	POC Approved
CTDT11	02/04/2009	02/05/2009	02/19/2009	

COMPLAINT/INCIDENT INFORMATION:

INTAKE ID	RECEIVED END DATE	STATUS	PRIORITY	DUE DATE	COMPLETED	FORWARD TO RO/MSA	DATE CLOSED	REASONS CLOSED
NV00018987	08/20/2008		Non-IJ Medium	10/04/2008	02/05/2009		07/13/2009	Paperwork Complete
NV00020672	01/21/2009		Non-IJ High	02/04/2009	02/05/2009		04/28/2009	Paperwork Complete

ALLEGATION INFORMATION:

INTAKE ID	CATEGORY	SUBCATEGORY	FINDINGS	LINKED TAGS (TAG - TITLE - SS - BUILDING)
NV00018987	Admission, Transfer & Discharge Right:		Unsubstantiated	
NV00018987	Resident/Patient/Client Neglect	Medications	Unsubstantiated	
NV00020672	Quality of Care/Treatment	Resident Not Groomed Adequately	Unsubstantiated	
NV00020672	Resident/Patient/Client Neglect	Medications	Unsubstantiated	

Facility ID: NVS2489AGC
Provider Number:

COMPLAINT/INCIDENT SURVEY REPORT
02/05/2009

SUMMARY OF CITATIONS:

TAG	SS	POC DATE	CORRECTED	STATUS	EVENT ID	EXIT DATE
State - Not Related to any Intakes:						
Y0070 QUALIFICATIONS OF CAREGIVER-8 HOUR	E			Not Corrected	CTDT11	02/05/2009
Y0103 PERSONNEL FILE - NAC 441A	F			Not Corrected	CTDT11	02/05/2009
Y0106 PERSONNEL FILE - 1ST AID & CPR	F			Not Corrected	CTDT11	02/05/2009
Y0173 HEALTH AND SANITATION-INSIDE GARBA	D			Not Corrected	CTDT11	02/05/2009
Y0175 HEALTH AND SANITATION-HAZARDS	F			Not Corrected	CTDT11	02/05/2009
Y0179 HEALTH AND SANITATION-SCREENS	D			Not Corrected	CTDT11	02/05/2009
Y0250 KITCHENS-EQUIPMENT WORKS; CLEAN A	D			Not Corrected	CTDT11	02/05/2009
Y0251 STORAGE OF FOOD-PERISHABLE FOODS	D			Not Corrected	CTDT11	02/05/2009
Y0278 DIETARY CONSULTANT - MORE THAN 10 I	B			Not Corrected	CTDT11	02/05/2009
Y0352 BATHROOMS AND TOILET FACILITIES	C			Not Corrected	CTDT11	02/05/2009
Y0451 FIRST AID KIT	D			Not Corrected	CTDT11	02/05/2009
Y0645 RATE AGREEMENT	B			Not Corrected	CTDT11	02/05/2009
Y0859 PERIODIC PHYSICAL EXAMINATION OF A	E			Not Corrected	CTDT11	02/05/2009
Y0870 449.2742(1)(A)(1) MEDICATION ADMINISTR	F			Not Corrected	CTDT11	02/05/2009
Y0876 NRS 449.037	B			Not Corrected	CTDT11	02/05/2009
Y0878 MEDICATION / CHANGE ORDER	D			Not Corrected	CTDT11	02/05/2009
Y0882 MEDICATION / CHANGE ORDER	D			Not Corrected	CTDT11	02/05/2009
Y0922 MEDICATION LABELING	D			Not Corrected	CTDT11	02/05/2009
Y0933 RESIDENT FILE-MENTAL, PHYSICAL CONI	B			Not Corrected	CTDT11	02/05/2009
Y0936 RESIDENT FILE-NRS 441A TUBERCULOSI	F			Not Corrected	CTDT11	02/05/2009
Y0938 RESIDENT FILE - ADL EVALUATION ADMI	B			Not Corrected	CTDT11	02/05/2009
Y0941 RESIDENT FILE - FACILITY RULES	C			Not Corrected	CTDT11	02/05/2009
Y0991 449.2756(1)(B) ALZHEIMER'S FAC DOOR A	F			Not Corrected	CTDT11	02/05/2009
Y0993 449.2756(1)(D) ALZHEIMER'S TRAINING	F			Not Corrected	CTDT11	02/05/2009
Y0999 ALZHEIMER'S FACILITY-TOXIC SUBSTANC	F			Not Corrected	CTDT11	02/05/2009
Y1001 TRAINING REQ-ELDERLY DISABLED	F			Not Corrected	CTDT11	02/05/2009
Y1010 MI TRAINING	F			Not Corrected	CTDT11	02/05/2009
Y1020 CHRONIC ILLNESS TRAINING	F			Not Corrected	CTDT11	02/05/2009

Facility ID: NVS2489AGC
Provider Number:

COMPLAINT/INCIDENT SURVEY REPORT
02/05/2009

ACTIVITIES:

INTAKE ID	ASSIGNED DATE	ACTIVITY	RESPONSIBLE STAFF MEMBER	DUE DATE	COMPLETED DATE
NV00018987	02/04/2009	Schedule Onsite Visit	[redacted]	02/04/2009	02/05/2009
NV00020672	02/04/2009	Schedule Onsite Visit	[redacted]	02/04/2009	02/05/2009

END OF INVESTIGATION INFORMATION

NEVADA BUREAU OF LICENSURE AND CERTIFICATION

QUALITY OF CARE COMPLAINT (NAC § 449.268)
AGAINST
LICENSED RESIDENTIAL FACILITY FOR GROUPS (NRS § 449.017; NAC § 449.156)

Name of Facility: Chancellor Gardens of the Lakes
Address of Facility: 2620 Lake Sahara Drive, Las Vegas, Nevada 89117
Name of Patient: [redacted]

Date of Birth: [redacted] **Date Admitted:** 12/10/2005 **Date of Death:** 09/20/2008

Summary of Complaint:

Chancellor Gardens of the Lakes ("Chancellor Gardens") failed to administer [redacted] medications and failed to clean her room, even though the doctor's Standard Placement Determination and the Wellness Service Agreement required them to do both. The administrator of the facility failed to ensure that [redacted] was not neglected or exploited by staff of the facility in violation of NAC § 449.268(1) and related criminal acts - elder neglect and exploitation - as defined in NRS § 200.5099.

Sanctions Requested:

- Imposition of a plan of correction as directed by the Bureau
- Monitoring of the facility by the Bureau
- Assessment of monetary penalties of at least $9,900 for reimbursement to [redacted] estate for medication management fees assessed by Chancellor Gardens and paid by [redacted] because Chancellor Gardens failed to provide medication management services.

Facts:

[redacted] became a resident of Chancellor Gardens on or around December 10, 2005. [redacted] resided at Chancellor Gardens with her pet cat until her death on September 13, 2008.

Prior to her admission into residence, a Standard Placement Determination form was prepared by [redacted] stating that [redacted] required placement in a facility "which provides care for persons who are elderly or disabled or who require assistance or protective supervision because they suffer from infirmities or disabilities," i.e., a NRS 449.017 residential facility for groups. A copy of the Standard Placement Determination is attached as Attachment One.

In accord with a Physician Assessment dated December 10, 2005, Chancellor Gardens was on notice that [redacted] was "forgetful at times," and unable to administer her own medications. The medications listed on the form included Namenda and Aricept, drugs prescribed to treat moderate to severe dementia. Used in concert, Namenda and Aricept are intended to help a patient with dementia improve and maintain thinking, significantly improve behavior, delay the

onset of negative behavioral symptoms, and maintain the ability to perform activities of daily living. A copy of the Physician Assessment is attached as Attachment Two.

Under her Wellness Service Agreement, [redacted] was charged a medication management fee of $300.00 each month for 33 months ($9,900). This fee was solely in consideration of Chancellor Gardens administering [redacted] medication daily. A copy of the Wellness Service Agreement is attached as Attachment Three, and a summary of invoices paid to Chancellor Gardens in respect of [redacted] care is attached as Attachment Four.

The State of Nevada appointed [redacted] and [redacted], as guardians of the person and estate of [redacted] on June 14, 2006. The appointment of guardians was due to the declining ability of [redacted] to handle her own affairs.

On September 9, 2008, [redacted] visited [redacted] at Chancellor Gardens and learned of the substandard, unsanitary conditions in which [redacted] was living. Her room was unkempt and it appeared that no housekeeping had been done for quite some time. The room reeked of cat urine and bags of trash were everywhere. Old newspapers soaked with cat urine had accumulated three inches deep in [redacted] closet. A baggie containing several months' supply of [redacted] accumulated medications, not administered to or taken by [redacted] was found in the drawer of her dresser. Copies of photographs taken by [redacted] are attached hereto as Attachment Five.[1]

Upon seeing the condition of the room and finding [redacted] medication, [redacted] asked [redacted], the Executive Director of Chancellor Gardens, and [redacted], a RN and Chancellor Gardens' Wellness Director in charge of residential care and services for [redacted], why the room had not been cleaned. [redacted] responded that [redacted] would not let them in to clean the room because of her cat. However, due to her dementia, [redacted] was not in a position to decide whether her room needed cleaning.

[redacted] also inquired about the accumulation of pills in [redacted] drawer and was told by [redacted], incorrectly, that [redacted] was a "self-medicator." [redacted] then tried to take the bag of pills from [redacted], but she refused to hand them over. [redacted] retains the bag of pills and can produce it if desired. [redacted] can authenticate the bag, if desired, because – when [redacted] refused to give it to him – he took a picture of the bag of pills with his camera phone.

[redacted] complained about the level of care being provided to [redacted] and were informed by [redacted] that it would not happen again.

[redacted] passed away from pneumonia four days later.

---

[1] The quality of the photographs is regrettably poor, but is the best that could be done with a cell phone in low light. Nevertheless, they accurately convey the general condition and appearance of Ms. Records room in Chancellor Gardens on September 9, 2008.

Discussion:

An administrator of a residential facility must ensure that residents of the facility are not abused, neglected or exploited by members of staff, that they are treated with dignity and respect, and that the facility is a safe and comfortable environment. NAC § 449.268(1). Furthermore, it is a crime for any person who has assumed responsibility pursuant to a contract for care for an older person to permit or allow the older person to be placed in a situation where the older person may suffer physical pain or mental suffering as a result of abuse or neglect. NRS § 200.5099.

Here, Chancellor Gardens failed to administer [redacted] medication, as required under her contract for care and as billed and paid for. Chancellor Gardens and its Administrator, [redacted], knew or should have known that the failure of the staff to administer [redacted] medication placed her in a position where she would be subjected to harm. [redacted] medications were intended to modify her behavior and to support her remaining ability to care for herself. Without proper administration of those medications, [redacted] was less capable of making day to day decisions, such as whether to take her medication or allow staff of the facility access to her room to clean it and maintain a habitable, sanitary environment. Furthermore, by not administering the medications, Chancellor Gardens exploited [redacted] and obtained a windfall by way of payments received for services not provided.

Chancellor Gardens also failed to provide a safe and comfortable environment to [redacted], who spent her final days in a filthy space inhaling toxic odors. Living in an enclosed space with breathing air contaminated by high levels of ammonia from three inches thick of newspapers saturated with cat urine may have contributed to [redacted] death, as she was admitted to the Summerlin Hospital on September 7, 2008 with a diagnosis of pneumonia and died less than two weeks later. "Where an individual who is responsible for the care of an older person has knowledge of facts and circumstances that would cause a reasonable person to believe an older person was in a situation that might require additional care or services, the failure to take steps to check out the situation may result in criminal liability if the actions or failure to act causes the older person to suffer harm." *Vallery v. State of Nevada*, 118 Nev. 357, 371 (2002). [redacted] was incapable of making her own decisions regarding the upkeep of her residence. Chancellor Gardens was on notice of her inability to distinguish harmful situations based on the intake forms filled out by [redacted]. The condition and odor of the room were health hazards that should have raised red flags for any reasonable person.

In failing to administer [redacted] medications or properly maintain a habitable living space, Chancellor Gardens neglected [redacted] and breached its contract with [redacted]. Accordingly, Chancellor Gardens should be sanctioned by the Bureau of Licensure and Certification. Moreover, monetary penalties should be assessed against Chancellor Gardens for the costs of [redacted] medication management fees in the amount of at least $9,900 with disposition to [redacted] estate for money lost pursuant to NAC section 449.99912.

Moreover, [redacted] should be held personally liable, as the designated administrator of the facility, for failing to insure that Chancellor Gardens adhered to all relevant codes and

regulations governing the facility. *See Vallery v. State of Nevada*, 118 Nev. at 361. [redacted] himself was responsible under Nevada regulations for providing protective supervision, and he had a duty of care to [redacted] failed in both regards by not ensuring that [redacted] took her medication and by not intervening when it became clear that [redacted] could not make decisions involving her care. These failures constitute neglect pursuant to NRS section 200.5099 for which [redacted] is personally liable.

Thank you for your consideration of this Complaint.

Sincerely,

[redacted]
Guardian and Daughter of [redacted]

Address:

[redacted]

Telephone: [redacted]

[redacted] **Guardian and Son of** [redacted]

Address:

_____

_____

Telephone:

The Bureau is welcome to contact [redacted] **and/or** [redacted] **at the addresses and phone numbers above. Communications to the Records' family may also be directed to their attorney:**

[redacted]